Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004426	A. BUILDING _____ B. WING _____	08/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDISON HOUSE	2244 Q AVE NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: August 16, & 17, 2011 Facility number: 004426 Provider number: 004426 AIM number: N/A Survey team: Angel Tomlinson RN TC Cheryl Fielden RN Census bed type: Residential: 23 Total: 23 Census payor type: Other: 23 Total: 23 Sample: 7 Addison house was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure survey. Quality review completed 8/19/11 Cathy Emswiller RN	R 000		